September 12, 2001

Tommy G. Thompson, Secretary
U.S. Department of Health and Human Services
Office of the Secretary
Hubert Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Thompson:

I am writing to request your assistance in determining if the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) apply to Wisconsin's Medicaid home and community-based waiver programs. This is a follow-up to a conference call held June 27, 2001, between my staff and staff from the Department of Health and Human Services. I am also sending you a separate letter dealing with whether other publicly funded programs are considered health plans under HIPAA. This issue was also discussed in the June 27 conference call.

We are working to meet the implementation deadline for the Standards for Electronic Transactions final regulation issued as part of HIPAA Administrative Simplification. However, to complete our compliance plans and provide guidance to our many business partners, we are trying to determine the applicability of these regulations to Medicaid home and community-based waiver programs. Community-based waiver services provide a cost-effective alternative to institutional care through the provision of services not otherwise available to Medicaid recipients.

We administer these waiver programs through contracts with county agencies. All 72 counties and one tribal government agency in Wisconsin administer the waivers. Under this type of arrangement, we are unclear if county agencies are covered entities under HIPAA rules. We are seeking clarification from the Department of Health and Human Services (DHHS) on the following issues:

- Are HIPAA regulations applicable to Wisconsin's home and community-based waiver programs?

- If so, are the county agencies that administer the waivers considered providers, health plans, business associates, or some other entity?

While Medicaid is clearly covered by the HIPAA regulations as a health plan, the waivers are administered differently from the Medicaid program. Our interpretation of the HIPAA regulations leads us to believe HIPAA does not apply to our waiver programs, as they provide primarily non-health care services and are not covered entities as defined by the regulation. The majority of waiver services are non-health care services, and are, therefore, not subject to the HIPAA standards. The preamble (page 50316) to the final Standards for Electronic Transactions supports this interpretation.

Further, the county and tribal agencies that administer the waivers in Wisconsin are not a covered entity, as defined at s. 160.103 of the regulation, as they are not a health plan, health care clearinghouse or health care provider.

To assist your staff, we attached a paper describing how our home and community-based waiver programs are administered. My staff is willing to provide any additional information your agency needs to provide us an expedited response to our inquiry. County agencies providing waiver services need a definitive, prompt response to proceed with possible HIPAA compliance planning. If you have any questions, please contact Ken Dybevik at (608) 267-7118.

Thank you for your assistance.

Sincerely,

Phyllis J. Dubé
Secretary

cc: Sally Canfield
Lawrence Cutler
Donna Eden
Sheila Frank
Harvey Heyman
Stanley Nachimson
Frank Valentino

Wisconsin Home and Community-Based Waiver Programs

Services Provided: All waiver participants are Medicaid eligible. While participants in the home and community-based waivers may have multiple chronic health problems, as a long-term care population, their principal needs, addressed by the waiver programs, are related to "functional disability," which prevents participants from providing their own essential daily activities (e.g., bathing, dressing). All health care needs are funded by the Medicaid State Plan, which is a health plan. The waivers can fund only social and environmental supports and services that Medicaid deems are not medically necessary. While waiver services are a mix of health care and non-health care services, the majority of these services are atypical services (e.g., home modifications), which are specifically excluded from the HIPAA regulations.

Other services provided by the waiver programs may be called the same thing as State Plan health care services and benefits (e.g., transportation, medical supplies); however, the waiver is only permitted to pay for these services if they are not covered by the State Plan, because they are not medically necessary. These services may be needed to carry out a vital daily activity, but are not provided as health care services by a health care provider to respond to a health problem.

Service Providers: A county care manager conducts a comprehensive assessment of consumer needs and develops a care plan for each waiver participant. For services funded under Medicaid, the care manager arranges with a Medicaid provider to deliver the services. For services funded under the waiver, the county either provides the service directly or the care manager contracts with a vendor for the service. Counties may purchase housekeeping or meal preparation from a neighbor, or purchase meals from Meals on Wheels. Supportive home care may be provided by a grandchild or an agency.

Providers of waiver services are typically non-traditional providers and non-health care providers (e.g., carpenters performing home modifications) or informal caregivers (e.g., family members, neighbors) that do not normally perform standard health care transactions or have access to the information necessary to perform such a transaction. For example, typical health care providers, such as physicians, submit health care claims to payers that include information such as diagnosis code. Providers of waiver services have not traditionally submitted claims to counties in standard formats or standard paper claim forms, and do not have access to the detailed medical information needed to submit a standard claim transaction now or under HIPAA standards.

Methods of Billing and Payment: For services covered by the Medicaid State Plan, providers submit claims directly to the State. The State makes payments directly to the providers via the Medicaid Management Information System (MMIS). In contrast, providers of waiver services submit abbreviated claims, bills or invoices for authorized services to the counties, not directly to the State. Each county pays its vendors for these services through locally designed payment systems. There are 72 unique fiscal and payment systems in county governments, which are typically used to pay for waiver services and any other county services (e.g., road maintenance or recycling).

The county submits monthly claims for all social services, including waivers, to the state Community Aids Reporting System (CARS) for actual costs in the aggregate. Claims are tied to the conditions of the State-County contract. State funds are awarded to counties on a formula basis to support a fixed number of waiver participants. The State makes a federal claim for the Medicaid match and pays out the full amount of waiver funds (State and Federal). The claims are for the entire county program and do not identify individual beneficiaries. The Medicaid match provided to the waiver programs is paid for benefits that are not part of the health plan, but are social and environmental supports that are an alternative to the health care.

Separately, the counties report for all social services, including the waivers, to the State's Human Services Reporting System (HSRS). Reporting includes individual demographic and client identifiers, and waiver services used by each individual, including the frequency and amount (unit) of service. Aggregate encounter data is reported monthly for each person. No financial claims are processed or made through this system. Data extracts from HSRS are put into the Medicaid Evaluation and Decision Support system (MEDS) for program analysis and federal reporting.

At DHFS, fiscal managers reconcile the fiscal payment data from CARS with the program reports from HSRS to verify that the services paid for were delivered. DHFS also reviews the program data to determine whether Medicaid matching funds were correctly claimed for allowable services. If a benefit is not permitted under the State Plan or the waivers (e.g., paying a spouse for care when a provider does not show up), State funds are used in place of Medicaid funds. Payment from DHFS to the counties is not made on the basis of individual services, as is typically done by health plans, but is for the costs of approved county programs.